Tobacco Free and Next Steps Discount Form

Use this form to certify your and your dependents' eligibility for the Next Steps and/or Tobacco Free discounts. Please visit www.benefits.mt.gov/discount for more information.

Eligibility:

- Covered under the state medical plan;
- At least 18 years old by Oct. 31, 2015; and
- Have completed a State sponsored health screening at a Montana Health Center or a remote health screening put on by CareHere between Jan. 1, 2015 and Oct. 31, 2015.
  - HCBD will be automatically notified if you have had your State sponsored health screening.
  - Can't remember if you've completed this step? Call CareHere at 855.200.6822.
- *You do NOT need to fill out the Cigna Online Health Assessment this year!*

Please return one completed form per household to Health Care and Benefits Division, PO Box 200130, Helena, MT 59620-0130, fax (406) 444-0080 or e-mail benefitsquestions@mt.gov. Partial or incorrect forms will NOT be accepted. Forms must be postmarked or returned to Health Care and Benefits Division by October 31, 2015.

Policyholder Name:	
Telephone Number (Cell, Home, or Work): __ __ __--__ __ __--__ __ __ __	**Date of Birth:** __ __--__ __--__ __ __ __ (MM-DD-YYYY)
E-mail address:	**Last 4 digits of social security number:** XXX-XX-__ __ __ __

Next Step Discount--Complete the information requested below for at least **FOUR** activities completed by you and/or your dependent between Nov. 1, 2014 and Oct. 31, 2015.

The following activities were completed by: ☐Member ☐Dependent **Name:**	
☐	Health Coaching /Management Program
☐	Exercise
☐	Dental Cleaning
☐	Vision Exam
☐	Vaccinations
☐	Annual Physical

The following activities were completed by: ☐Member ☐Dependent **Name:**	
☐	Health Coaching /Management Program
☐	Exercise
☐	Dental Cleaning
☐	Vision Exam
☐	Vaccinations
☐	Annual Physical

1. **Health coaching or an approved Lifestyle/Condition Management Program.** At least one visit with a health coach or completion of an approved lifestyle or condition management program. Visit benefits.mt.gov/discount to see a full list of approved programs.
2. **Exercise**. You routinely exercise at least three days per week for 15 minutes or more, on average.
3. **Dental Exam**. A routine cleaning and check-up.
4. **Eye Exam**. A routine eye exam and vision check-up.
5. **Vaccinations**. Examples include but are not limited to flu (influenza), shingles, tetanus/whooping cough.
6. **Routine Annual Physical Exam**. Yearly head-to-toe check-up that includes recommendations for indicated preventive cancer screenings

TURN OVER →

MUST SIGN ON OTHER SIDE

Tobacco Free and Next Steps Discount Form

Tobacco Free Discount--Complete the information requested below to certify your tobacco use status.

- Mark "I am tobacco free" if you have never used tobacco or have quit using tobacco.
- Mark "I have completed a tobacco cessation program" if you have finished all requirements of a tobacco cessation program between Jan. 1, 2015 and Oct. 31, 2015, but are not currently tobacco free. *This still qualifies you for the Tobacco Free discount.*
- Mark "I use tobacco" if you currently smoke, chew or use any other kind of tobacco product. *If you mark this box, you will not receive the Tobacco Free Discount.*

Tobacco Use Status ☐Member ☐Dependent **Name:**	
☐	I am tobacco free.
☐	I use tobacco.
☐	I have completed a tobacco cessation program.

Tobacco Use Status ☐Member ☐Dependent **Name:**	
☐	I am tobacco free.
☐	I use tobacco.
☐	I have completed a tobacco cessation program.

If you have a medical reason why you cannot complete *any part* of the Live Life Well Incentive program, please contact the Health Care and Benefits Division at (406)444-2044 to learn about alternatives and exceptions.

By signing below, I acknowledge that I will not be eligible for any additional discount if each member being certified has not first completed a State sponsored health screening. I certify that all information is true and correct. I understand that I may be asked to provide verification of the activities, and that I will lose eligibility for the Next Steps Discount if I cannot provide verification that the activities have been completed by me or my dependent as claimed, if requested to do so. I understand that if my dependent is removed from my plan during the plan year, I will lose their portion of the discount. If you have entered information for a dependent, you certify that you have the dependent's permission to provide the information.

_____ _____

Member Signature Date